CHECKLIST FOR HIV TESTING, CALIFORNIA NON-PREGNANT PATIENT

NAME OF PERSON TO BE TESTED:_____

If provider initiates test offer, begin with Part B

A. ☐ Patient independently requests test from provider (not offered first by provider)[1]
Perform test, then proceed to Part C after test (skip part B)

B. HIV testing offered by provider[1]

Note: HIV test must be offered at least once by primary care clinic for ages 15-65, if blood is to be drawn for other purposes, and no test or refusal is on file within past 12 months[2]

1. ☐ Patient has been informed of intent to do an HIV antibody test as a part of routine medical care.
2. ☐ Patient has been provided information about HIV antibody test, including:
   - that numerous treatment options for HIV/AIDS are available if the test is positive
   - that if the test result is negative, periodic testing should continue to be routinely done (if he or she continues to have potential exposure)
3. Method of providing above information *(documentation recommended, not required by law)*:
   ☐ Handout covering the above[3]
   ☐ Above information discussed orally with patient
4. ☐ Patient has been informed that he or she has the right to decline the test, and:
   ☐ Patient does not refuse test
   ☐ Patient refuses test
   (Documentation of refusal in chart by medical care provider is required; signature below confirms refusal if this box is checked.)

Signature, Medical Care Provider:_____ Date:_____

C. Post-test Counseling[1]

☐ Patient has received explanation **of** the results and the implications for the patient's health.

If the patient tests positive for HIV infection:

☐ Patient has been informed that there are numerous treatment options available.
☐ Patient has been informed about testing and care that may be recommended, including contact information for medical and psychological services.

If the patient tests negative for HIV infection and is known to be at high risk for HIV infection:

☐ Patient has been advised of the need for periodic retesting, and of the limitations of current testing technology and the current window period for verification of results.
☐ Patient has been offered prevention counseling or a referral to prevention counseling (optional).

Signature, Medical Care Provider:_____ Date:_____

Legal and Patient Info. References: *(Beyond AIDS/Foundation assume no liability for usage, see . www.beyondaids.org/helpforca.html)*

[1] *Health and Safety Code, Section 120990, as amended effective 1/1/14. (Pre-test requirements of Part B above are not applicable if patient initiates test request.)*

[2] *Health and Safety Code, Section 120991, effective 1/1/14*

[3] *Handout developed by California Department of Public Health for pre-test information: "HIV Testing in Health Care Setting," links labeled as "Frequently Asked Questions for HIV testing, available as free download in 13 languages:* https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_hivhcv.aspx